Stirling Behavioral Health Institute

Clinitrak® EDI Implementation

Clinitrak Implementation Timeline

- Stirling signed the contract with Clinivate in late February 2007
- Staff training at the two main sites was conducted in March/April
- System entered full use (all Progress Notes being created on-line) about 60 days after signing the contract
- Stirling decided to hold-off on EDI until the beginning of the new Fiscal Year
- Clinitrak began EDI testing in July 2007; Stirling received its EDI Production Digital Certificate and began submitting all claims at the end of July
- Stirling is currently submitting over 2000 claims for over $250,000 per month. Average rate of approval is 98.3%

Clinitrak Software Features

- Clinitrak has two-factor authentication using CryptoCard user authentication technology;
- Clinitrak produces DMH-compatible Service Logs to facilitate Manual billing until the Agency moves to EDI;
- Automatic Upgrades (e.g. addition of NPI fields that were already included in Clinitrak);
- Clinitrak's Auto-validation of Claims and identifies potential billing problems;
- One-click submission of batched claims automatically links Agency's claim number with the claim ID produced by DMH
- Clinitrak status flags facilitate tracking of Submitted and Un-Submitted Claims
- Ability to Void and Re-Submit claims
- Ability to Sort Claims data by Date of Service, Reporting Unit, Provider, and Client.
- Clintrak provides real-time access to the latest approval data downloaded from DMH

Other Nice Stuff

- Clinitrak's EDI Interface facilitates immediate access to the original note;
- The Reports Module facilitates reconciliation of claims data with original notes;
- The built-in Revenue Tracking Report compares provisional rate data with SMA rates;
- The Cost Report Wizard automates the collection and display of year-to-date rate and productivity data; and
- The contract provides easy access to support from knowledgeable Clinivate personnel

Contract Provider Lessons Learned Outline

The following outline can be used to assist you in preparing your "Lessons Learned" discussion for the CPTT Workgroup. Thank you again for your participation.

Topics to Cover

1. Agency Overview
    a. What types of programs are provided by your agency? Are you a FSP?
    We do Medi-Cal, Healthy Families, AB3632, some CalWorks, and a little LA Family Housing. We are not an FSP.
    b. How many service locations, clinicians, and clients do you have?
    We have 2 service locations, 20 clinicians, 400+ clients
    c. What systems does your agency have installed (clinical management, electronic health record, other)?
    We use Clinitrak for EDI Billing and electronic health records

2. Implementation Process
    a. Describe the implementation process (testing, training, data cleanup, etc.)
    There were a couple of training sessions. The software is pretty intuitive. See Clinitrak Implementation Timeline.
    b. How long did it take to do the implementation?
    About 2 months.
    c. Did you install the software at your facility or are you using an Application Service Provider (ASP)?
    Software is web-based.
    d. Did you hire consultants to assist you during the process?
    No.
    e. What new staff was required if any?
    None. It's actually cut down a lot on the hours and hours I used to spend on green sheet data entry. I now am freed up to spend hours and hours micromanaging claim by claim approval.
    f. Contract negotiation – describe the process, key contract language included, what should have been included, enforcement of the contract.
    I believe that we went over the contract with a fine-toothed comb. We made sure that the procedure to change/alter the software was spelled out in the contract. We got assurances that the software would work, and we agreed on a pre-set amount for any future customization of the software.

3. Operational Changes
    a. What kind of changes did you make in your day-to-day operation?
    It's changed everything. Data entry has become claims approval management. Patients records are now electronic. QA can now be done anytime, anywhere. Supervisors can easily review all notes. Productivity is quickly calculated.

Daily tasks:
1. Data transfer:
    A: check DMH EDI production site.
    B: Transfer data.
2: Billing
    A: Check billing ready claims.
    B: Submit claims.
3: Claims processing
    A: Monitor changes in claim status regarding data transfer.
    B: Check denied and pending claims
    C: fix errors
    D: resubmit claims

b. Did you implement new policies, procedures, other changes?
   Nothing other than obvious things like new training, etc.
c. How do you reconcile claims – batches, IS and CICS error handling, Medi-Cal errors, correcting and resubmitting batches?
   We are now able to manage pending claims. In the past, pending claims were just in limbo. We never had any idea how many claims were pending and what DMH was doing with them. Learning how to fix denied and pending claims has been hit-and-miss, but it's only gotten better and better. We are just over a year using EDI and we are at an 87.4% approval rate and a 2.9% denial rate for the claims that have been submitted to DMH since EDI inception June 1st of last year.
d. What reconciliation tools do you use – SIFT, IS Reports, Vendor reports, custom reports or data extracts, other?
   I use IS reports. SIFT is usually too old, complicated, and difficult to decipher for me. I've just found that it was easier to learn how to fix claims without SIFT than to learn SIFT. I start with Clinitrak data and proceed to the IS.
e. What new skill sets/staff roles are required for EDI – billing analysts, technical staff, and other roles?
   We've just retrained existing staff on the new system.
f. How did the staff accept the new system?
   Hit and miss. Everyone seems to have adjusted by now. I think some of the initial problems we had were existing QA problems that became more visible when EDI billing/electronic health records were implemented.
g. Describe your latest State and/or County audit process? Review electronic signatures, electronic records, medical files, etc.
   We have not had an audit covering our EDI billing period.

4. Budget and Costs
    a. What was your planned budget for the system?
       I don't know.
    b. What were your actual costs?
       I don't know.
    c. What are your ongoing costs?

I don't know.

5. Benefits
    a. What benefits did you expect to realize with EDI or EHRS?
    Improved organizational efficiency, HIPPAA compliance
    b. What benefits have you realized after your implementation?
    Built in QA – dates, CCCP, etc. checked.
    Integration of billing and medical records.
    See Software Features.

6. Lessons Learned
    a. What advice would you give other providers regarding the implementation of EDI and/or Electronic Health Records System?
    Lots of patience is required. But it's well worth it. It's taken longer to master the new system than initially expected, but the benefits are much greater than expected.

    Setup tip: We used SIFT data to populate Clinitrak client and therapist data. Be sure to go through IS caseload and rendering provider reports and make sure they are 100% accurate before transferring data. This will save a lot of cleanup time.

    It is a lot easier to get help from Clinivate than DMH. This is due to overworked/understaffed DMH EDI help team. Billing specialist will want to cultivate relationship with at least two of the team members.

    In the past, we lost revenue because we overran funding source maximum contracted amounts. Clinitrak helps us track services provided with up-to-the minute accuracy.

    Productivity management is much easier. We can check how many notes a therapist enters. We can see draft and unfinished notes. We can check whether supervisors are countersigning notes in a timely manner and view unsigned notes. We get a report on missing data required for billing, etc.

    If there are any administrative errors, it is very easy to void claims.

    Bottom line: Clinitrak is fast and easy, and we have the ability to pursue billing on every single individual claim.

    For last fiscal year, 87.4% is approved, 2.9% is denied, and 9.7% is pending.